Vaughn Municipal Schools

101 East Fourth Street
P.O. Box 489
Vaughn, NM 88353
Phone 575-584-2283 Fax 575-584-2355

Dear Parents/Guardians:

This is the Enrollment Packet VMS will be using for the 2024-2025 school year. The enrollment packet is the same one used last year. So, again we are trying to eliminate the large packet used in the past. If the forms have not changed, all that will be required is that a parent/guardian sign the signature page. If a form has changed, it will be attached for the parent/guardian to read over and sign that individual form. If you would like a full enrollment packet or if you want to read the forms before signing the signature page, they will be provided at the time of enrollment.

NOTE: **anyone enrolling for the first time at VMS will be required to complete a full enrollment packet.**

***The following forms listed require parent/guardian signature. The forms listed are also the forms that have not changed and only require a parent/guardian signature.**

Student Name: _____ **Grade:**_____

- **MEDIA RELEASE**

  ☐ **NO**, I do not wish to release photo/name of my student.

  ☐ **YES**, you may release photo/name of my student.

- **BULLYING/HARASSMENT CONTRACT:**
- **USE OF ELECTRONIC DEVICES IN SCHOOL:**
- **OFFICIAL NOTIFICATION OF ACCEPTABLE USE PROCEDURES FOR COMPUTER SYSTEM AND THE INTERNET:**

Parent/Guardian Signature _____ **Date** _____

Student Signature_____ **Date**_____

Vaughn Municipal School
Enrollment Form

Grade Level _____ Date of Enrollment _____ NM ID #_____

STUDENT INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name
Date of Birth	Birth City	Birth State/Country

PARENT/GUARDIAN INFORMATION - **EMAIL** _____

Parent/Guardian Last Name	**Parent/Guardian First Name**	**Phone Number**
Parent Last Name	Parent First Name	Phone Number
Mailing Address	Physical Address	City, State, & Zip code
Mailing Address	Physical Address	City, State, & Zip code

1st Emergency Contact (Non-Parent/Guardian) **Relationship-**_____

Last Name	First Name	Phone Number

2nd Emergency Contact (Non Parent/Guardian) **Relationship-**_____

Last Name	First Name	Phone Number

3rd Emergency Contact (Non Parent/Guardian) **Relationship-**_____

Last Name	First Name	Phone Number

STUDENT HEALTH HISTORY

Parent/Guardian: The purpose of this form is to identify problems that may affect learning for the student. Please indicate if your child has had or is currently under treatment for any of the following conditions. Give year or age when problem occurred.
Your child's health history will only be shared with school employees that need to know in order to keep your child safe and healthy in school

*The school nurse is available to help you at #*_____ ☐M ☐T ☐W ☐Th ☐F)

Student Name:_____ DOB:_____ Student #:_____

Person Providing History:_____ Relationship to Student:_____

Is this person the biological parent? **Y** ☐ **N**☐

Home Phone:_____ Work Phone:_____ Cell Phone: _____

DEVELOPMENTAL HISTORY

1. Has the student received physical, occupational, speech, or language therapy? **Y** ☐ **N** ☐
   If **Y**, explain:_____
2. Are you or has anyone ever been concerned about the student's development? **Y**☐ **N**☐
   If **Y**, explain:_____

HEALTH HISTORY

Check any of the following which the student currently has or has had diagnosed in the past.

☐Asthma
☐Allergies
☐Anaphylaxis
☐Anemia
☐ADD/ADHD
☐Behavioral problems
☐Bleeding problems
☐Braces
☐Chicken Pox
☐Dental problems
☐Developmental problems
☐Diabetes
☐Frequent ear infections
☐Eczema
☐Glasses/contacts
☐Vision problems
☐Frequent Urination
☐Head/Spinal injury
☐Depression
☐Frequent Headaches
☐Hearing Aids
☐Hearing problems
☐Heart problems
☐Hemophilia
☐Hernia
☐High Blood Pressure
☐Hives
☐Hypoglycemia
☐Kidney problems
☐Nerve or muscle disease
☐Meningitis
☐Shingles
☐Migraines
☐Excessive thirst
☐Rheumatic Fever
☐Heart problems or murmur
☐Recurrent Rashes
☐Ingestion of poisons/medication
☐Vaccine Preventable Diseases
☐Convulsion or seizures
☐Skin problems
☐Speech problems
☐Stomach problems
☐Thyroid problems
☐Tuberculosis
☐Cancer
☐Life changing events/accidents

Explain any check mark and give age of problem onset or diagnosis or any problems not listed:_____
_____
_____
_____
_____

1. List any allergies to food, insects, latex: _____
_____

2. List any allergies to medications and happened with medication:_____

_____

3. List any other diagnosis, syndrome or disability the student has or has had in past. (List condition, treatment, who diagnosed, etc.) _____

_____

4. Has the student had more than 3 colds, sinus infections, or ear infections in any one year? **Y☐ N☐**
If **Y**, explain:_____

5. Has the student ever had any vision or hearing problems? **Y☐ N☐**
If **Y**, explain:_____

6. **Medication** - Is the student taking medication now? **Y☐ N ☐**
If **Y**, list the medications (include prescribed, over-the-counter, herbal and other remedies) and the condition for which the student takes this , dosage, and how often): _____

_____

_____

_____

_____

Has the student ever taken any medication for longer than two weeks? **Y☐ N☐**
If **Y**, list medication and when it was taken?_____

_____

7. **Nutrition** – Student eats at least 3 meals each day. **Y☐ N☐**
Student: ☐has healthy appetite ☐is picky eater ☐is sometimes picky ☐ is sometimes not picky.

Do you have any concerns about student's eating? **Y☐ N☐**
If **Y**, explain:_____

Do you have any concerns about student's physical activity? Y☐ N☐
If **Y**, explain:_____

Does student have any food allergies? **Y☐ N☐**
If Y, explain:_____

8. Has student had any surgeries? _____

_____

9. Does student have any limitations for physical activity? _____

_____

MEDICAL CARE

Primary Care Provider:_____ Phone #: _____

Other providers/physicians/specialists:_____

Medical Insurance: Medicaid/Salud MCO:_____
Medicaid #:_____
Other Insurance/Coverage:_____
☐ No Other Insurance/Coverage

Date of last physical exam:_____ Date copy of provider report requested: _____

Summary of Findings:_____

Date of last dental visit/exam:_____ Summary of Findings:_____

By signing below I am agreeing to the information on this form is current and correct to the best of my knowledge. I understand that if the medical status of my child changes in any significant way, I will notify his/her school nurse of the change. I also understand that my child's health/medical information may be shared with other school staff members to ensure my child's health and safety while at school.

Parent or Legal Guardian Name:_____

Parent or Legal Guardian Signature:_____ Date:_____

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STUDENT EMERGENCY INFORMATION

(ONE FORM PER STUDENT)

NAME OF STUDENT_____

PARENTS: _____ _____
MOTHER/GUARDIAN FATHER/GUARDIAN

In case of emergency, I/We_____ _____
Authorize for the following person (s), **with proper identification**, to pick-up our child after school or check out our child from school.

_____ _____
Name of Person Relationship

_____ _____
Name of Person Relationship

_____ _____
Name of Person Relationship

_____ _____
Name of Person Relationship

****

I,_____ am enrolling _____
Parent/Guardian Relationship Student
on this day_____.

ONLY, THE FOLLOWING PERSON(S) MAY DISENROLL MY CHILD FROM SCHOOL, OTHER THAN MYSELF.

_____ _____
Name of Person Relationship

_____ _____
Name of Person Relationship

_____ _____
Signature of Parent/Guardian and Date **Signature of Parent/Guardian and Date**

Phone Number _____
***Please notify the school if there is any change on the above information.**

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STUDENT HOUSING QUESTIONNAIRE

The answers to the following questions help determine educational services your child(ren) may be eligible to receive through the McKinney-Vento Homeless Assistance Act.

Are you 'doubled up' with another family due to a loss of housing or economic hardship?	☐ Yes	☐ No
Are you living in a motel/hotel due to lack of housing?	☐ Yes	☐ No
Are you living in a shelter?	☐ Yes	☐ No
Are you living in a car, park, campsite or location not usually used for sleeping accommodations?	☐ Yes	☐ No
Is this student awaiting foster care?	☐ Yes	☐ No
As a student, are living with someone other than your parents?	☐ Yes	☐ No

- If you answered YES to **any** of the above question, please complete the remainder of this form.
- If you answered NO to all of the above questions, you stop here.

Student Name: _____
First Middle Last

Date of Birth:_____ Age:_____ Grade____ Name of School:_____

Current Address: _____
Street/P.O Box City Zip

Phone/Contact Number:_____

Do you have other children that attend a school in the Vaughn Municipal School District?

Name _____ Date of Birth: _____ Age ___ Grade ___ School _____

Name _____ Date of Birth: _____ Age ___ Grade ___ School _____

Name _____ Date of Birth: _____ Age ___ Grade ___ School _____

I declare under penalty of perjury under the laws of the State of New Mexico that the information provided here is true and accurate.

Signature of person completing form: _____ *Date:* _____

Relationship to the student(s): *Parent* ☐ *Guardian* ☐ *Self* ☐ Other _____

For School Staff Only: If "Yes" is checked for any question above, please give this form to the School Counselor or Administrator

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General field Trip Permission Form

I hereby give my permission for _____
to take school field trips during the 2024-2025 school year.

Parent Consent

I understand that extended learning experiences present fun and exciting opportunities for student learning, as well as heightened exposure to risk of injury – ranging from minor to serious – not normally encountered in the classroom. Such exposure may be in the form of transportation to/from the activity, or participation in experiences such as walking on trails, playing in parks, riding amusement rides, etc.

Further, I understand that every reasonable effort will be made to safeguard the health and safety of all participants. Accidents can occur however, and I agree to hold harmless the Vaughn Municipal School District, its elected and appointed officials, employees, agents, and staff from any and all claims, liabilities, damages, expenses, or rights of action, directly or indirectly attributed to my child's participation in these field trip activities, except for the sole negligence of the District.

_____ _____

Parent/guardian Signature **Date**

Medical Treatment Information and Consent

In the event that my child should need medical attention during the trip and I am unavailable for consultation, the supervisor has my permission to acquire medical attention. Known medical problems, allergies, or medications needed are described below.

Medical Information: _____
Allergies: _____
Medications: _____

_____ _____

Parent/guardian Signature **Date**

Telephone Numbers:

Home: _____ Work: _____
Emergency Contact 1: _____ Phone: _____
Emergency Contact 2: _____ Phone: _____

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

OFFICE OF ORAL HEALTH

DENTAL SCREENING AND SEALANT INFORMATION FOR PARENTS

Dear Parent or Guardian:

The Department of Health/Office of Oral Health provides **FREE** dental screenings and dental sealants at your child's school to help prevent tooth decay. These services are not charged to you or your insurance. School sealant programs are an effective way to provide children with sealants to prevent cavities. Our team will provide a safe environment for both your child and our staff.

Services provided to your child:

Dental Screenings: A Dental Professional will determine if your child needs to be seen by their Dentist for further dental treatment. A note will be sent home with the child; if your child does not have a Dentist, our team will assist your family in identifying a Dentist for your child.

Dental Sealants: Dental sealants are safe to put on your child's teeth. Dental sealants are thin coatings painted on the chewing surfaces of the back teeth (molars) that can prevent cavities for many years. If there are concerning areas on a tooth, a sealant will not be placed and further evaluation by your child's dentist would be highly recommended.

Regular dental visits are encouraged since they are important for your child's oral health.

Please fill out the provided consent form and return it to your child's teacher tomorrow.

- If you wish for your child to participate, please complete the "Yes" area, continue filling in the entire form and return to your child's teacher.
- If you *do not* wish to have your child participate, please complete the "No" area on the form, sign and return to your child's teacher.

IMPORTANT

The Office of Oral Health is required by law to protect your privacy. The law is called the Health Insurance Portability and Accountability Act. https://www.nmhealth.org/help/privacy

If you have any questions, please call the Office of Oral Health based to your nearest location in Santa Fe at (505) 827-0837, in Albuquerque at (505) 220-4152, or in Las Cruces at (575) 528-5087.

THANK YOU

(Español a el otro lado)

OFFICE OF ORAL HEALTH

CONFIDENTIAL CONSENT FOR AN ORAL HEALTH SCREENING AND DENTAL SEALANTS

YES, I want my son/daughter _____ (child's name) to participate in the school dental program by receiving **FREE** limited oral health screening(s) **and** dental sealant(s) provided by the Office of Oral Health. ***(Please fill out the entire form below)***

- I understand that these services are provided under the New Mexico Department of Health, Public Health Division, Office of Oral Health.
- I understand that this **DOES NOT** replace the need for regular dental visits.
- I understand records created and maintained as part of this program are the property of the New Mexico Department of Health.
- I understand that this consent is valid for one year upon the date of signature unless withdrawn in writing by the parent or guardian.

I understand that this consent is valid for one year upon the date of signature unless withdrawn in writing by the parent or guardian.

Parent /Guardian Name ***(please print)***: _____

Parent/Guardian Signature: _____ **Date:** _____

NO, I *do not* want my son/daughter _____ (child's name) to participate in the school dental program.

(Please fill in the child's name above and collect parent/guardian signature. No further action required.)

Parent/Guardian Signature: _____ **Date:** _____

Name of Child *(first)*: _____ *(last)* _____ **Grade**: _____

Date of Birth _____/_____/_____ (Month) (Day) (Year) **Gender** ☐ **Male** ☐ **Female** **Best Phone # to reach family** ( )_____

Address _____ **City** _____

State _____ **Zip Code** _____ **County** _____

School _____ **Teacher** _____

Ethnicity (Please Check One)	**Race** (Check all that applies)
☐ **Not Hispanic or Latino** ☐ **Hispanic**	☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **Native American** ☐ **Pacific Islander** ☐ **Other**

DENTAL HEALTH HISTORY *(Please Circle)*

Does your child see a dentist regularly? _____ **Yes** **No**

My child's most recent dental visit was: **Date:** _____/_____ (Month) (Year) ☐ never seen a dentist

Does your child have dental insurance? *(Please circle)*: **Private Dental Insurance** **Medicaid** **None**

Who is your child's dental provider? _____

GENERAL HEALTH HISTORY

1. Does your child have any health or heart problems? _____ **Yes** **No**
   If yes, please explain: _____
2. Is your child taking medication on a regular basis? _____ **Yes** **No**
   If yes, please list: _____
3. Is your child allergic to any medications or products? _____ **Yes** **No**
   If yes, please list: _____
4. Does your child have a disability or special care needs? _____ **Yes** **No**

All children are eligible regardless of immigration status, you do not need to be a US Citizen to receive our services.
Should you have questions about the dental sealant program please call the Office of Oral Health at (505) 827-0837.

OFFICE OF ORAL HEALTH
1190 St. Francis Dr., Suite 1050 • P.O. Box 26110 • Santa Fe, New Mexico • 87502
(505) 827-0837 • www.nmhealth.org

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

The Health Insurance Portability Act of 1996 requires health agencies to provide a Notice of Privacy Practices to all persons receiving services. This form acknowledges that you have received the New Mexico Department of Health Notice of Privacy Practices.

CLIENT		
	Client Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy) / /
	Client Address (Street or P.O. Box, City, State, Zip Code)	Telephone Number ( )

I acknowledge that I was offered or provided a copy of the New Mexico Department of Health (NMDOH) Notice of Privacy Practices.

SIGNATURES		
	Signature of Client or Personal Representative	Date (mm/dd/yyyy) / /
	If Signed by Personal Representative, Relationship to Client	

- ❑ Acknowledgment entered into Chief Privacy Officer Database.
- ❑ The following good faith efforts were made to obtain acknowledgment from the client or the client's personal representative. Please check all that apply.
- ❑ Offered the client or the client's personal representative a copy of the Notice of Privacy Practices and the client or the client's personal representative declined to sign the Acknowledgment Form.
- ❑ Provided answers to any questions from the client or the client's personal representative regarding the NMDOH Notice of Privacy Practices.